

Facility Name & ID Number Alden Naperville Rehab & HCC

0022509 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,298	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,298	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	3,501	1,519	3,225	8,245	8
9	SNF/PED					9
10	ICF	40,265	6,918	2,150	49,333	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,766	8,437	5,375	57,578	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.50%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/79

J. Was the facility purchased or leased after January 1, 1978?

YES NO X

K. Was the facility certified for Medicare during the reporting year?

YES X NO If YES, enter number of beds certified and days of care provided

2,875

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number		Alden Naperville Rehab & HCC				STATE OF ILLINOIS		#	0022509	Report Period Beginning:		1/1/00	Ending:	Page 3	12/31/00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)															
	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY					
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10				
	A. General Services														
1	Dietary	428,348	29,439		457,787	830	458,617		458,617						1
2	Food Purchase		374,227		374,227	(35,082)	339,145	(14,303)	324,842						2
3	Housekeeping	199,992	26,956		226,948	641	227,589		227,589						3
4	Laundry	63,332	23,365		86,697	256	86,953		86,953						4
5	Heat and Other Utilities			140,643	140,643		140,643		140,643						5
6	Maintenance	46,061		178,763	224,824	93	224,917	(18,141)	206,776						6
7	Other (specify):*														7
8	TOTAL General Services	737,733	453,987	319,406	1,511,126	(33,262)	1,477,864	(32,444)	1,445,420						8
	B. Health Care and Programs														
9	Medical Director			18,875	18,875		18,875		18,875						9
10	Nursing and Medical Records	1,927,851	124,890	13,707	2,066,448	3,417	2,069,865	(478)	2,069,387						10
10a	Therapy	26,411			26,411	1,211	27,622		27,622						10a
11	Activities	156,135	4,329	618	161,082		161,082	(31,336)	129,746						11
12	Social Services	36,802		8,618	45,420		45,420		45,420						12
13	Nurse Aide Training			1,450	1,450		1,450		1,450						13
14	Program Transportation														14
15	Other (specify):*														15
16	TOTAL Health Care and Programs	2,147,199	129,219	43,268	2,319,686	4,628	2,324,314	(31,814)	2,292,500						16
	C. General Administration														
17	Administrative	59,770			59,770		59,770		59,770						17
18	Directors Fees														18
19	Professional Services			708,417	708,417		708,417	(645,728)	62,689						19
20	Dues, Fees, Subscriptions & Promotions			120,831	120,831		120,831	(98,593)	22,238						20
21	Clerical & General Office Expenses	501,646	22,367	34,387	558,400	276	558,676	62,191	620,867						21
22	Employee Benefits & Payroll Taxes			403,361	403,361	29,198	432,559	54,893	487,452						22
23	Inservice Training & Education														23
24	Travel and Seminar			1,270	1,270		1,270	15,914	17,184						24
25	Other Admin. Staff Transportation														25
26	Insurance-Prop.Liab.Malpractice			49,810	49,810		49,810	163	49,973						26
27	Other (specify):*			18,000	18,000		18,000	(18,000)							27
28	TOTAL General Administration	561,416	22,367	1,336,076	1,919,859	29,474	1,949,333	(629,160)	1,320,173						28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,446,348	605,573	1,698,750	5,750,671	840	5,751,511	(693,418)	5,058,093						29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			107,014	107,014		107,014	92,548	199,562			30
31	Amortization of Pre-Op. & Org.			490	490		490	1,902	2,392			31
32	Interest			78,422	78,422		78,422	6,389	84,811			32
33	Real Estate Taxes			86,374	86,374		86,374	6,650	93,024			33
34	Rent-Facility & Grounds			982,160	982,160		982,160	(982,160)				34
35	Rent-Equipment & Vehicles			8,535	8,535		8,535	21,030	29,565			35
36	Other (specify):*											36
37	TOTAL Ownership			1,262,995	1,262,995		1,262,995	(853,641)	409,354			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		132,391	389,521	521,912		521,912	(175,754)	346,158			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,447	111,447		111,447		111,447			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		132,391	500,968	633,359		633,359	(175,754)	457,605			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,446,348	737,964	3,462,713	7,647,025	840	7,647,865	(1,722,813)	5,925,052			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (32,176)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	77,233	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,461)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,135)	32		18
19	Entertainment				19
20	Contributions	(2,486)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)	27		24
25	Fund Raising, Advertising and Promotional	(25,459)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(16,542)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,026)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(571,724)	pg. 6'	34
35	Other- Attach Schedule	(1,130,063)	pg. 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,701,787)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,722,813)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0022509

1/1/00

12/31/00

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	non-cost: hmo nursing supply(gl 5026)	\$ (4,588)	39	1
2	non-cost: hmo drugs supply(gl 5042)	(9,281)	39	2
3	non-cost: hmo therapy (gl 5040)	(42,608)	39	3
4	non-cost: part b therapy c/a's in 5212/3/4	(6,046)	39	4
5	non-cost: hmo isolation c/a (gl 5093)	(3,690)	39	5
6	ELIMINATE RENT RESULTING FROM SALE/L.B.	(982,160)	34	6
7	reclass massage therapy from ln19 -ln11	840	11	7
8	reclass massage therapy from ln19 -ln11	(840)	19	8
9	Promo& events 5K accts (gl 5741&5726)	(54,701)	20	9
10	PG 21 back out prior year exp. (gl 5720)	573	24	10
11	painting>\$1500 for 2000 reclass from ln 6 to pg 22	(8,585)	6	11
12	record deprec exp on painting reclassified for 1999	4,115	6	12
13	record deprec exp on painting reclassified for 2000	1,431	6	13
14	insurance settlement revenue backed out	(24,524)	6	14
15				15
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88				88
89				89
90	Total	(1,130,063)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Naperville Rehab & HCC # 0022509 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,461)	0	0	(12,842)	0	0	0	0	0	0	0	(14,303)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(27,563)	0	9,422	0	0	0	0	0	0	0	0	(18,141)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(29,024)	0	9,422	(12,842)	0	0	0	0	0	0	0	(32,444)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(478)	0	0	0	0	0	0	(478)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(31,336)	0	0	0	0	0	0	0	0	0	0	(31,336)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(31,336)	0	0	0	(478)	0	0	0	0	0	0	(31,814)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(840)	0	(644,808)	0	0	0	0	(80)	0	0	0	(645,728)	19
20	Fees, Subscriptions & Promotions	(99,188)	0	595	0	0	0	0	0	0	0	0	(98,593)	20
21	Clerical & General Office Expenses	0	0	39,640	11,554	10,997	0	0	0	0	0	0	62,191	21
22	Employee Benefits & Payroll Taxes	0	0	55,616	0	(723)	0	0	0	0	0	0	54,893	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	573	0	15,341	0	0	0	0	0	0	0	0	15,914	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	163	0	0	0	0	0	0	0	0	163	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	TOTAL General Administration	(117,455)	0	(533,453)	11,554	10,274	0	0	(80)	0	0	0	(629,160)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(177,815)	0	(524,031)	(1,288)	9,796	0	0	(80)	0	0	0	(693,418)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	77,233	0	15,315	0	0	0	0	0	0	0	0	92,548	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	1,902	0	0	0	0	1,902	31
32	Interest	(2,135)	0	5,377	0	0	0	3,147	0	0	0	0	6,389	32
33	Real Estate Taxes	0	0	6,650	0	0	0	0	0	0	0	0	6,650	33
34	Rent-Facility & Grounds	(982,160)	0	0	0	0	0	0	0	0	0	0	(982,160)	34
35	Rent-Equipment & Vehicles	0	0	21,030	0	0	0	0	0	0	0	0	21,030	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(907,062)	0	48,372	0	0	0	5,049	0	0	0	0	(853,641)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(66,212)	0	0	(13,354)	(38,525)	0	(57,663)	0	0	0	0	(175,754)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(66,212)	0	0	(13,354)	(38,525)	0	(57,663)	0	0	0	0	(175,754)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,151,089)	0	(475,659)	(14,642)	(28,729)	0	(52,614)	(80)	0	0	0	(1,722,813)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	\$	Alden Management Services, Inc.		\$ 9,422	\$ 9,422	15
16	V	19	professional fees	657,720	Alden Management Services, Inc.		12,912	(644,808)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		595	595	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		39,640	39,640	18
19	V	22	employee costs		Alden Management Services, Inc.		55,616	55,616	19
20	V	24	auto/seminar		Alden Management Services, Inc.		15,341	15,341	20
21	V	26	insurance		Alden Management Services, Inc.		163	163	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		5,377	5,377	23
24	V	33	real estate tax		Alden Management Services, Inc.		6,650	6,650	24
25	V	35	auto lease		Alden Management Services, Inc.		21,030	21,030	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 657,720			\$ 182,061	\$ * (475,659)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	\$ 18,189	Pyramid Healthcare Services	0.00%	\$ 5,347	\$ (12,842)	15
16	V	39	nursing supplies	6,082	Pyramid Healthcare Services		4,447	(1,635)	16
17	V	39	supplies/per diem fee	32,552	Pyramid Healthcare Services		20,833	(11,719)	17
18	V	21	general & administrative				11,554	11,554	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 56,823			\$ 42,181	\$ * (14,642)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	\$129,741	Forum Extended Care II	0.00%	\$97,660	\$(32,081)	15
16	V	10	house stock	1,935	Forum Extended Care II		1,457	(478)	16
17	V	39	iv	26,061	Forum Extended Care II		19,617	(6,444)	17
18	V	22	vaccinations	2,922	Forum Extended Care II		2,199	(723)	18
19	V	21	general & administrative		Forum Extended Care II		10,997	10,997	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$160,659			\$131,930	\$*(28,729)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	\$ 271,940	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 214,277	\$ (57,663)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		1,902	1,902	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		3,147	3,147	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 271,940			\$ 219,326	\$ * (52,614)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	constructions management fees	\$ 5,665	ALDEN BENNETT CONSTRUCTION	0.00%	\$ 5,585	\$ (80)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 5,665			\$ 5,585	\$ * (80)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg	President -AMS	Chief Executive	100.00%	182,767	2.404	6.01	Salary	\$ 11,680	21-1	1
2	Lauren Magnusson	Clinical Coordinator	Nursing Review	a	70,016	2.404	6.01	Salary	4,474	21-1	2
3	Terry Magnusson	Administrator/other	admin/mainten	b	71,777	2.404	6.01	Salary	1,843	21-1	3
4	Audra Schlossberg	Massage/Therapist	Massage/Therapy	c	6,011	0.253	0.10	Fees	840	21-1	4
5											5
6											6
7											7
8											8
9											9
10	a. Lauren Magnusson is the daughter of Floyd Schlossberg and worked as a Clinical Coordinator for Alden Management Services for all of 2000.										10
11	b. Terry Magnusson is the son-in-law of Floyd Schlossberg and worked as the Administrator of Alden -Valley Ridge for 7 months thereafter he worked as in										11
12	Construction / Maintenance for Alden Management Services.										12
13								TOTAL	\$ 18,837		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Naperville Rehab & HCC # 0022509 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Alden Management Services, Inc.
Street Address 4200 W. Peterson
City / State / Zip Code Chicago, Illinois 60646
Phone Number (773) 286-3883
Fax Number (773) 286-3743

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2		SEE PAGE 8A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	PRO FORM ALLOCATON OF						\$		\$			\$	1		
2	INTEREST ON SALE/LEASEBACK	X		ORIGINAL MORTGAGE	\$31,412.59	1979		3,200,000		06/21/99	0.1025	32,861	2		
3													3		
4													4		
5	OMEGA HEALTHCARE		X	REMODELING	\$5,332.75	1988		500,000	419,923	2014	0.1218	43,426	5		
	Working Capital														
6	RELATED PARTY - AMS	X		OPERATIONS	NONE						VARIES	5,377	6		
7	RELATED PARTY -CPT	X		OPERATIONS	NONE						VARIES	3,147	7		
8	LINE OF CREDIT		X	OPERATIONS	NONE						VARIES		8		
9	TOTAL Facility Related				\$36,745.34		\$	3,700,000	\$	419,923			\$	84,811	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$			\$		14	
15	TOTALS (line 9+line14)						\$	3,700,000	\$	419,923			\$	84,811	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	98,025	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	89,951	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(8,074)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	94,448	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	86,374	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	91,935	8
	1996	93,134	9
	1997	94,458	10
	1998	93,357	11
	1999	89,951	12
	FOR OFF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,063

B. General Construction Type: Exterior BRICKFrame STEELNumber of Stories 3

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 14,692

2. Number of Years Over Which it is Being Amortized: 30

3. Current Period Amortization: 490

4. Dates Incurred: April - Oct 1988

Nature of Costs: Amortize construction period interest 11/00

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1980	\$ 656,000	1
2					2
3	TOTALS			\$ 656,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	206		1980	1979	\$ 2,333,433	\$	30	\$ 77,781	\$ 77,781	\$ 1,633,406	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	bells/doors			1981	876		20	44	44	862	9
10	elevator repair			1982	2,796		8			2,796	10
11	repair water sys;roof;install windows/grab bars			1983	21,739		5-20	1,047	1,047	19,981	11
12	circuit breaker repair			1984	4,478		20	224	224	3,621	12
13	electical repair & water tower repair			1987	5,403		3			5,403	13
14	complete building renovation			1987	43,055	65	3-20	65		42,633	14
15	complete building renovation			1988	725,437	30,408	3-30	30,408		485,212	15
16	water tower repair/electrical repair			1987	7,293		3			7,293	16
17	repair telphone sys;electical laundry			1988	3,890		5			3,890	17
18	repair pumppls./laundry;decoratoin			1989	17,943	543	5-20	543		13,377	18
19	water heater			1990	8,793		5			8,793	19
20	renovation			1991	24,099	861	5-20	861		14,703	20
21	repari water heater boiler freezer condenser			1991	8,380		5			8,380	21
22	repair water heater/freeZer/ssprinkler syst/a/c			1992	19,357	469	5-25	469		17,712	22
23	wallcovering hot water heater/paving/doors alarm syst			1993	45,517	3,369	5-15	3,369		29,019	23
24	plumbing /valves/pvaving			1994	22,139	1,700	10-20	1,700		11,102	24
25	repair water tower/fire alarms electical /roof wash.mach			1995	45,492	3,360	10-20	3,360		19,021	25
26	install door/frame			1996	2,200	220	10	220		1,082	26
27	replace condenser			1996	5,073	338	15	338		1,381	27
28	new cooling tower			1996	15,140	1,009	15	1,009		4,878	28
29	install amp panel/new circuits			1997	2,670	534	5	534		2,136	29
30	new valve			1997	1,710	342	5	342		1,226	30
31	recaulking			1997	7,475	1,495	5	1,495		4,859	31
32	new bearings/hvac/etc.			1998	4,317	863	5	863		2,590	32
33	Gen'l Parts- boiler repairs			1997	4,033	202	20	202		655	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 3,382,737	\$ 45,778		\$ 124,874	\$ 79,096	\$ 2,346,009	36

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	4	
5										5	
6										6	
7										7	
8										8	
	Improvement Type**										
9	CSI (replaced valves,relief)			1998	3,200	640	5	640		1,866	9
10	Atash(cleaned & tested dampers)			1998	3,465	693	5	693		1,964	10
11	Climate Service (fixed compressor and plate)			1998	8,747	583	15	583		1,555	11
12	ETC Carpet (carpet)			1998	1,118	224	5	224		559	12
13	Climate Service (repair chiller and safety controls)			1998	3,718	372	10	372		867	13
14	Patten (repair generator)			1998	1,986	99	20	99		240	14
15	Firemen Sealcoating (sealcoat asphalt parking lot)			1998	3,995	200	20	200		433	15
16	CSI-install thermometer/hvac-hot water)			1998	2,975	595	5	595		1,636	16
17	Chicago Cooling(repair a/c)			1999	2,171	217	10	217		326	17
18	Chicago Cooling(repair a/c pump)			1999	2,835	283	10	283		425	18
19	Harold Scales(4 dehumidifiers)			1999	2,115	211	10	211		282	19
20	Climate Services(ice machine repair)			1999	2,055	205	10	205		274	20
21	Fox Valley Fire & Safety(install door holders)			1999	1,568	157	10	157		196	21
22	Sterling Services(carpet maintenance)			1999	1,600	320	5	320		400	22
23	ABC: MISC LABOR			1999	2,278	228	10	228		285	23
24	ABC: CARPENTRY REPAIRS			1999	2,404	240	10	240		280	24
25	Sterling Services(carpet maintenance)			1999	1,600	320	5	320		373	25
26	Climate Services, Inc (boiler repair)			2000	9,048	829	10	829		829	26
27	Climate Services, Inc (boiler repair)			2000	1,654	138	10	138		138	27
28	Climate Services, Inc (Replace dampers)			2000	6,950	579	10	579		579	28
29	Climate Services, Inc (main coil , misc. piping)			2000	31,846	1,327	20	1,327		1,327	29
30	Poblocki & Sons (room ID"S)			2000	5,398	202	20	202		202	30
31	D. B. S Contracting (signs lighting)			2000	2,300	96	12	96		96	31
32	Alden Bennett Construction (major repair time & billing by fac)			2000	1,696	85	10	85		85	32
33	Fox Valley Fire & Safety (safety system)			2000	2,351	118	10	118		118	33
34	GT Mechanical, INC (heater safety defrost fan relay)			2000	1,700	57	10	57		57	34
35	Alden Bennett Construction (major repair time & billing by fac)			2000	4,658	1,863	10		(1,863)	1,863	35
36	TOTAL (lines 4 thru 35)				\$ 115,430	\$ 10,882		\$ 9,019	\$ (1,863)	\$ 17,256	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	GT Mechanical, INC (suction, discharge & expansion valve)			2000	6,684	1,337	10	1,337		1,337	9	
10	Coker Service (replace vessel, steam safety valve & ignition wire)			2000	5,906	49	10	49		49	10	
11	Alden Bennett Const-time/material build.improv.			2000	3,248	27	10	27		27	11	
12											12	
13	CONTINUED...										13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$ 15,838	\$ 1,413		\$ 1,413	\$	\$ 1,413	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	RELATED			1978	\$ 12,184	\$ 554	22	\$ 554	\$	11,565	4
5	PARTY			1978	5,953	271	32	271		4,767	5
6	(FORUM)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 58,177	\$ 3,514		\$ 3,514	\$	215,231	36

*Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$607,744	\$50,899	\$50,899	\$	VARIOUS	\$817,868	37
38	Current Year Purchases	82,917	6,135	6,135		VARIOUS	6,135	38
39	Fully Depreciated Assets	119,592	1,214	1,214		VARIOUS	119,592	39
40								40
41	TOTALS	\$810,253	\$58,248	\$58,248	\$		\$943,595	41

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
42	VARIOUS	VAN, BUSES, ENGINE	1998-2000	\$26,682	\$2,494	\$2,494	\$	3	\$3,030
43									43
44									44
45									45
46	TOTALS			\$26,682	\$2,494	\$2,494	\$		\$3,030

E. Summary of Care-Related Assets				1	2
		Reference			Amount
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)			\$5,065,118
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)			\$122,329
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)			\$199,562
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)			\$77,233
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)			\$3,526,534

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
52		\$	\$	\$
53				
54				
55				
56				
57	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
58		\$
59		
60		
61		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:OMEGA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		203		\$ Eliminated due to			3
4	Additions				SALE/LEASEBACK			4
5								5
6								6
7	TOTAL		203		\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
-

9. Option to Buy:☒ YES☐ NO
- Terms:Right of first refusal at FMV*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☒ YES☐ NO
16. Rental Amount for movable equipment: \$8,535Description:Copy Machine Lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	RELATED PARTY	VARIOUS	\$ #####	\$ 21,030	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 21,030	21

10. Effective dates of current rental agreement:

Beginning10/31/96
Ending10/31/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	\$ 902,960
13.	/2002	\$ 722,467
14.	/2003	\$ 0

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.			
SKILLED NURSING IS ALREADY ON SITE			

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 123,378	\$		\$ 123,378	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			26,712			26,712	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			121,852			121,852	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PG 16A...	# of prescripts				70,426		70,426	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PG 16A...					3,791		3,791	13
14	TOTAL			\$		\$ 271,942	\$ 74,216		\$ 346,158	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,205	\$	1
2	Cash-Patient Deposits	29,813		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 253,234)	1,986,179		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,215		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	537,785		8
9	Other(specify): deferred taxes	121,297		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,841,494	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,258,820		15
16	Equipment, at Historical Cost	785,107		16
17	Accumulated Depreciation (book methods)	(1,263,633)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe various	8,734		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 789,029	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,630,523	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,086,019	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,832		28
29	Short-Term Notes Payable	10,881		29
30	Accrued Salaries Payable	293,456		30
31	Accrued Taxes Payable (excluding real estate taxes)	69,873		31
32	Accrued Real Estate Taxes(Sch.IX-B)	94,592		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	third party	3,737,939		36
37	accrued exps/due IDPA/other	541,640		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,872,233	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	409,042		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 409,042	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,281,275	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,650,752)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,630,523	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,558,121)	1
2	Restatements (describe):		2
3	external auditors' adjustments made after 1999 cost report		3
4	was filed: no effect on allowable costs for 1999: bad debts,		4
5	medicare revenue: no effect on reimbursable costs	(331,071)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,889,192)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	238,440	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 238,440	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,650,752)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,334,999	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,334,999	3
	B. Ancillary Revenue		
4	Day Care	32,176	4
5	Other Care for Outpatients		5
6	Therapy	86,521	6
7	Oxygen	11,397	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 130,093	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,248	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	45	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,300	21
22	Laundry	315	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,908	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	insurance settlement (backed out on line 5A)	24,524	28
28a	* Adj's made to prior year expenses.	5,661	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 30,185	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,501,185	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,511,126	31
32	Health Care	2,319,686	32
33	General Administration	1,535,579	33
	B. Capital Expense		
34	Ownership	1,262,995	34
	C. Ancillary Expense		
35	Special Cost Centers	521,912	35
36	Provider Participation Fee	111,447	36
	D. Other Expenses (specify):		
37	Note: this will not balance with page 3&4 due to related party		37
38	amounts that are on page 3 & 4.		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,262,745	40
41	Income before Income Taxes (line 30 minus line 40)**	238,440	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 238,440	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,992	2,080	\$ 59,114	\$ 28.42	1
2	Assistant Director of Nursing	2,081	2,089	41,579	19.90	2
3	Registered Nurses	19,220	21,004	496,263	23.63	3
4	Licensed Practical Nurses	17,804	18,845	361,628	19.19	4
5	Nurse Aides & Orderlies	83,595	89,052	844,741	9.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,590	2,948	26,411	8.96	8
9	Activity Director	1,824	2,080	45,621	21.93	9
10	Activity Assistants	6,972	7,778	110,515	14.21	10
11	Social Service Workers	8,019	8,483	110,632	13.04	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,080	41,397	19.90	13
14	Head Cook	5,703	6,497	98,920	15.23	14
15	Cook Helpers/Assistants	30,770	32,609	288,033	8.83	15
16	Dishwashers					16
17	Maintenance Workers	1,832	2,080	46,061	22.14	17
18	Housekeepers	19,786	21,699	199,992	9.22	18
19	Laundry	7,017	7,520	63,332	8.42	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,859	4,543	88,605	19.50	22
23	Office Manager	4,027	4,138	45,246	10.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,941	2,181	50,693	23.24	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical sup. Super	1,905	1,983	42,445	21.40	33
34	TOTAL (lines 1 - 33)	222,889	239,689	\$ 3,061,228 *	\$ 12.77	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	618	11-3	44
45	Social Service Consultant	4	206	12-3	45
46	Other(specify) Alzheimers	80	8,000	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	\$ 8,824		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES			
A. Administrative Salaries		Ownership	
Name	Function	%	Amount
SCOTT McBRIDE	ADMINISTRATOR	0.00%	\$ 59,770
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 59,770
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			Amount
Vendor/Payee	Type		
ALDEN MNG. SERVICES	MANAGEMENT FEE	\$	657,720
BLACKMANN KALLICK	ACCOUNTING FEE		11,400
KENNETH FISCH	LEGAL FEES		12,639
GREENBERG&HERMAN	LEGAL FEES		9,363
CHICAGO-KENT COLLEGE	LEGAL FEES		692
LMDBL&T TOMINBERG, LTD	LEGAL FEES		5,293
ALDEN DESIGN GROUP	DESIGN FEES		3,511
ACHEVE ACCRED	JHCACO CONSULTANT		480
IVES RYAN GROUP	ACRCHITECTUAL FEES		(629)
ALDEN BENNET CONSTRUC.	CONSTRUCTION FEES		5,665
US GAS & Other misc.fees	Utility Consult & Misc. Fee		2,283
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 708,417
D. Employee Benefits and Payroll Taxes			Amount
Description			
Workers' Compensation Insurance		\$	44,206
Unemployment Compensation Insurance			17,333
FICA Taxes			234,069
Employee Health Insurance			87,235
Employee Meals			35,082
Illinois Municipal Retirement Fund (IMRF)*			
dental/life insur/empl.relat/misc p/r			3,706
vaccinations/tuition			8,066
401K MATCH			2,864
RELATED PARTY			54,893
TOTAL (agree to Schedule V, line 22, col.8)			\$ 487,452
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			9,176
Health Care Worker Background Check (Indicate # of checks performed)			
RELATED PARTY			595
FIRE ALARM INSPECTION			1,085
CITY OF NAPERVILLE INSPECT.			270
DUPAGE COUNTY INSPECTION			525
VARIOUS LICENSE/INSPECT/DUES			797
IL. HEALTH CARE ASSOC.			9,790
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 22,238
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			1,843
RELATED PARTY			15,341
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	17,184

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	AC VENT	12/90	\$ 1,895	5	\$ 0	\$	\$	\$	\$	\$	\$	\$	\$
2	VENT REPAIR	1/92	1,873	5	0								
3	REPLACE PUMP	3/92	3,388	5	111								
4	REPLACE PUMP	6/92	3,742	5	532								
5	VALVE	8/92	2,147	5	252				Continue on page 22A & 22B...				
6	WALLPAPER	12/92	1,909	5	347								
7	PAINTING	12/92	3,800	5	696	0							
8	WALL COVERING	2/93	3,180	5	636	53							
9	PAINTING	3/93	363	5	73	17							
10	PAINTING	10/93	3,900	5	780	585							
11													
12													
13	HUMIDIFYING PUMP	9/97	1,582	3	176	527							
14	REPLACE BELT	3/98	3,510	3		975	1,170	1,170	195	0			
15	REPAIR PIPES	3/98	1,633	3		454	544	544	90	0			
16	WATER BALANCE	6/98	1,896	3		369	632	632	263	0			
17	PAINTING	6/98	4,517	3		878	1,506	1,506	628	0			
18	PAINTING	9/98	2,738	3		304	913	913	609	0			
19	PAINTING	12/98	4,829	3		134	1,610	1,610	1,476	0			
20	TOTALS		\$ 46,902		\$ 3,603	\$ 4,296	\$ 6,374	\$ 6,374	\$ 3,260	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Assoc. \$9,008
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,579 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? YES
If YES, give effective date of lease. 10/31/96
- (9) Are you presently operating under a sublease agreement? YES X YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,447
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? daycare For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 35,082 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Blackman Kallick Bartlestein, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.